BABY ARIZONA

FOR MOTHERS &

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BABY ARIZONA PARTICIPATING PROVIDER AGREEMENT

I wish to participate in the Baby Arizona program and will send
_____ and _____
of my staff to a training session to be held in my area
by Department of Economic Security staff.

I understand that I may withdraw my practice from this program at any time upon written notice to AHCCCS, 701 E. Jefferson, MD 6700, Phoenix AZ, 85034, attention: Maternal Child Health Coordinator.

I further understand that by practicing in the program I agree to the following:

- My name, practice address, and phone number may be given to a potential patient by the ADHS Pregnancy Information Hotline and other participating referral system.
- When contacted by a referred patient or the hotline, my office will schedule an appointment to assist in the S.O.B.R.A. eligibility process pursuant to the training we have received.
- My office will perform the same clinical services for a referred patient on the initial visit that we provide patients referred from other sources.
- If a patient is subsequently determined not to be S.O.B.R.A. eligible, we will continue her care based upon a reasonable payment schedule developed between my office and the patient.
- If a patient determined eligible is assigned to another provider or opts to receive care from another provider, we will transfer her records to that provider within ten (10) working days of receiving a signed release from the patient.

_____ _____
Physician/Designee Date

_____
Practice Name (if different)